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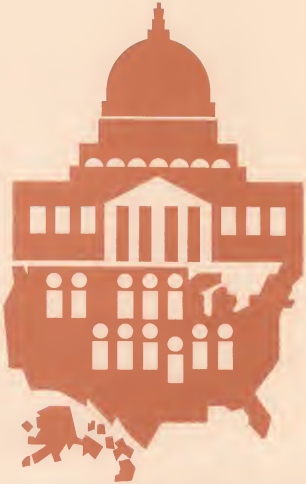
Legislative Snapshot:



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HOSPICES

by
Catherine Butler

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HOSPICES

A Snapshot of 1980-82 Laws

Catherine Butler

Rapidly rising costs and pressure for more humane health care for the terminally ill have led to the recent emergence of a hospice movement in America, patterned after the hospice system established at St. Christopher's in England in 1967. Present day hospices, similar in concept to the hospices of Medieval Europe, treat terminally ill patients and their families as units, providing palliative and supportive care for the final six months of the patient's life and the following period of family bereavement. Concern for the entire family and the attempt to keep the patient at home until death are what make the hospice program so different from traditional care.

The first American hospice program was established in Connecticut in 1974. Five years later, the Government Accounting Office had listed 59 existing hospices and 73 in the planning stages. The 1981 directory of the National Hospice Organization (NHO) lists 500 operating programs, about half of which are affiliated with the NHO, but estimates from this and a variety of other sources put the actual number of operational hospices between 600 and 1,000.

A 1982 HHS-funded comparative study of American hospices shows two types of hospice programs emerging: independent, predominantly volunteer hospices which deliver a great amount of social/psychological home services, and institutionally based hospices that provide inpatient care and more medical/nursing services, but fewer social/psychological services. Another distinguishing feature is that the volunteer type of hospices are confronted with major funding problems. The institutional type reported 50 percent fewer funding problems, suggesting that financial support is a big advantage of institutional affiliation.

The hospice boom has encouraged legislative action in several states. Since passage of the first hospice law in Connecticut in 1978, 14 states have passed a total of 24 laws or regulations specifically pertaining to hospices. Twelve of these laws were passed in 1980-81, and three more had been enacted as of June 1982.

Since the 1979 IHPP hospice snapshot, **COLORADO, DELAWARE, FLORIDA, HAWAII, ILLINOIS, MARYLAND, MICHIGAN,** and **VIRGINIA** have adopted hospice

legislation. Most of these laws deal with the definition of hospice care or the determination of licensure and regulatory procedures. **DELAWARE, KENTUCKY, MARYLAND** and **VIRGINIA** adopted some form of the NHO definition of hospice, which describes a coordinated, interdisciplinary program of home and inpatient palliative and supportive care, 24 hours a day, 7 days a week. **ILLINOIS** defines hospice more broadly, as "specialized care for the terminally ill," while **MICHIGAN** includes hospice under the definition of a health facility or agency.

Licensure requirements were added in five states in 1980-81, mandating that providers in **FLORIDA, KENTUCKY, MARYLAND, MICHIGAN** and **VIRGINIA** obtain licenses before operating hospices. The application process differs widely from state to state: **MARYLAND** requires merely the name and age of the applicant, the name of the person in charge and the location of the facility, while **KENTUCKY** and **FLORIDA** require submission of a comprehensive plan for care delivery. **MICHIGAN** and **VIRGINIA** laws are not specific about licensure applications. Laws passed in **FLORIDA** and **MARYLAND** in 1981 also require hospices to obtain a certificate of need (CON) before licensure.

Three states established task forces to study hospices in 1980-81. **DELAWARE's** task force consisted of a diverse group of professionals who were to study the need for a state hospice program and recommend regulation. The **FLORIDA** task force was to review license applications and renewals and conduct inspections. **VIRGINIA** appointed a subcommittee to help recommend standards, licensure and reimbursement of hospices.

MICHIGAN, in accordance with the NHO definition, specifically requires hospices to be under the direction of a physician, and **MARYLAND's** law requires that a licensed physician be on call 24 hours a day, 7 days a week. **FLORIDA** mandates that the majority of hospice services be provided directly by the licensee, and requires inpatient care to meet both the needs and preferences of the patient and family. (A 1982 **FLORIDA** law prohibits the Department of Health from making specified rules concerning the governing of hospices.)

Two laws were passed for the sole purpose of promoting and encouraging hospice growth. **HAWAII** legislation praises and encourages a pioneering effort by a hospital-based hospice planning a freestanding facility. **COLORADO** sent a 1982 hospice resolution to Washington, urging Congress to support a bill concerning hospice reimbursement.

At the federal level, Congressman Leon Panetta (D-Cal.) introduced legislation (HR 5180) in December 1981 which would make hospice care reimbursable under Medicare. Panetta cited an independent cost analysis (Warner-Lambert Foundation) which compared the cost of caring for the terminally ill under the current Medicare system to the cost under a program which included hospice coverage as an option. The study concluded that, using current Medicare coverage, the average cost of care for terminally ill patients in the last six months of life is five times greater than the average cost of hospice care as determined by the National Cancer Institute.

During testimony on HR 5180, the Health Care Financing Administration (HCFA) warned the subcommittee against "embracing expansions that could lead to unexpected consequences," and strongly recommended holding a decision on Medicare coverage until after the results of HCFA's two-year demonstration program become available in late 1983. Congress, nevertheless, adopted the amend-

ment extending Medicare coverage of hospice care for the terminally ill beginning January 1, 1984. Benefits include nursing care, medical social services, therapies, homemaker-home health aide services, physician services, short-term inpatient care, and outpatient drugs for pain relief. A 5 percent co-payment for outpatient drugs and respite care is required. The provision expires on September 30, 1986. A Congressional Budget Office report estimates that the new provision could save Medicare $16 million in 1985 and as much as $40 million in 1986.

Blue Cross/Blue Shield, which has been encouraging hospice demonstration programs among its plans since 1978, will extend hospice care benefits only through late 1982. According to BC/BS Vice President James Gillman, hospice care payments will end in December unless Medicare coverage for hospice care is begun and other carriers are required by the government to offer similar benefits.

The week of November 7-14, 1982, has been designated National Hospice Week by SJR 170, which was introduced by Senator Jennings Randolf (D-W.Va.) and passed in mid-1982.

State-By-State Summary of Hospice Legislation for the Years 1980, 1981, and 1982

COLORADO

HJR 1007 (1982)—This resolution urges the Congress of the United States to support the passage of S 1958 and HR 5180, which would modify Medicare provisions to include coverage for hospice care. Copies of this resolution are to be sent to the President of the Senate and the Speaker of the House, and to each Colorado congressman.

The standards proposed by the Colorado Hospice Coalition are deemed appropriate and necessary to the organization and the delivery of hospice care.

DELAWARE

HR 250 (1980)—The Department of Health and Social Services is requested to establish a task force, consisting of a diverse group of health professionals, consumers and bipartisan legislators, to study the need for a state hospice program. The task force was to define hospice and recommend regulation, reporting to the legislature within one year.

HJR 22 (1981)—The 1980 task force recommendation is adopted, defining hospice as a coordinated program of home, outpatient and inpatient care providing palliative and supportive medical and other health services by an interdisciplinary staff, 24 hours a day, 7 days a week.

The resolution also requests that the task force submit legislation in 1982 to establish quality standards.

FLORIDA

SB 628, Chapter 64 (1980)—The provisions of this bill:

- Remove "hospice program" from the definition of hospice.
- Define "autonomous" as a separate and distinct entity, operating under its own administration and bylaws, within or independent of a parent organization.
- Include services under the Community Care for the Elderly Act in those not considered hospice care.
- Exempt from the act volunteer organizations formed before 1980 which do not charge for their services. These organizations immediately become subject to the provisions if they start to charge.

SB 631, Chapter 271 (1981)—These amendments require inpatient hospices (freestanding or part of a facility) which are not licensed as "health care

facilities'' to obtain a CON. The formula on which a CON is based must discourage regional monopolies and promote competition.

A hospice license may be issued to any nonprofit agency or person who has:

- submitted a plan for hospice care delivery consistent with this law and rule;
- implemented, within three months of licensing, a hospice home care service; and
- obtained a CON for a hospice.

The plan for delivery of care must contain:

- estimated average number of persons to be served monthly;
- the geographic area in which services will be available;
- a list of available services;
- contractual arrangements with existing providers;
- the names and qualifications of any existing or projected contracts;
- projected annual operating cost of the hospice
- a statement of financial resources and personnel; and
- if applicable, the most recent licensure inspection report.

Applications for license renewal must be accompanied by an updated plan for service only if the original plan is no longer applicable.

If homelike inpatient and outpatient components are not operational within 12 months, or if the home care component is not in place after 3 months, the license will be revoked.

Florida has a policy of exemption for institutionally based, volunteer, non-charging hospices established before 1980. Such hospices are exempt from this law as long as they do not start to charge. Volunteer hospices exempt under 1980 law and incorporated before May 25, 1981, do not need a CON unless they increase services or facility capacity. A new department is established to monitor these organizations.

The majority of services available through a hospice must be provided directly by the licensee. Contracts with other facilities or providers must specify that the hospice retains planning, coordinating and prescribing responsibilities for patient care. Also, no hospice which contracts for service will charge for hospice services which are duplicative of contractual ones.

Beds designated for inpatient hospice care through contract with another health care facility are not required to be delicensed. Such beds will remain licensed to the health care facility, and hospices will not be required to obtain a CON for the number of such designated beds. No hospice may contract to use a licensed bed in a health care facility which, in the last 18 months, has had a conditional license, accreditation, or rating.

The inpatient component of care must meet both the needs and preferences of the patient and family. Rooms are limited to double occupancy (both hospice patients) in order to facilitate overnight family visitation.

Fees for inpatient hospice care must be available to the Hospital Cost Containment Board. Location and hours of service should be determined by accessibility of services to patients and their families.

The amendments add a section on licensure inspections which creates a task force (members specified) to review license applications and conduct annual inspections. The task force must establish criteria and standards for license applica-

tion and renewal including:

- the need and supply of services;
- the methodology for reviewing contractual agreements and their impact on local health care delivery; and
- a review of the quality of components of care delivered by the hospice.

Contracts which designate 20 percent more licensed health care facility beds for hospice inpatient care than are used by terminally ill patients on an average monthly basis will not be approved. The task force will limit contractual beds for new hospices applying for a license until the applicant can demonstrate a need for additional beds. The task force must make rules to ensure the availability of a continuum of quality hospice care which enables the patient to stay at home as much as possible.

SB 672, Chapter 82-102 (1982)—This law prohibits the Department of Health and Rehabilitative Services from adopting certain rules concerning the governing of hospices. No rule or policy of the Department may:

- govern contracts for hospice use of existing beds, but this does not relieve a hospice from the requirement to create a homelike atmosphere;
- require a hospice to establish more than one committee exclusive of the hospice care team and a governing body, or require any committee to meet more often than quarterly;
- require a hospice to employ full-time personnel, other than the patient care coordinator;
- establish staffing standards for inpatient hospice care in excess of standards required under the hospice license;
- require a specific room to be designated for hospice care if the hospice contracts for beds with an existing health care facility; or
- require freestanding inpatient hospice facilities with six or fewer beds to comply with institutional standards.

HAWAII

Senate Resolution 271 (1980)—St. Francis Hospital has a hospital-based hospice and is planning a freestanding hospice facility. The Senate congratulates and encourages this pioneering effort.

ILLINOIS

SB 1815 (1980)—This bill defines hospice as a program which provides specialized care for terminally ill persons. It adds to the Civil Administration Code the requirement to provide education and consultation in relation to hospice care.

MARYLAND

SB 718, Chapter 736 (1981)—This act amends the Annotated Code of Maryland. It defines "freestanding hospice care facility" as a separate facility housing two to eight nonrelated persons, which provides a medically directed, interdisciplinary program of palliative care for patients with less than six months to live, and also provides supportive care to their families.

Persons must be certified to provide freestanding hospice care. To get a certificate, a person must apply and:

- assure that the applicant is at least 18 years of age, of reputable and responsible character;
- give the name and location of the proposed facility;
- state the name of the individual in charge and give any addition pertinent information; and
- present a CON.

Application fee is $10, paid into the general fund, and the certificate is good for three years. No applicant who has ever been convicted of nursing home fraud or a Medicaid-related felony will be issued a certificate.

The facility's structure must meet safety standards for single family residences of the county or municipality. The structure may not have to comply with institutional safety standards.

Each facility is required to have a licensed physician on call 24 hours a day, 7 days a week, and must have an adequate supportive staff.

Rules and regulations will be promulgated by the Secretary of Health and Mental Hygiene in consultation with the Hospice Reimbursement Study Commission.

SB 191 (1982)—This law requires nonprofit health service plans, as well as insurance companies and HMOs, to provide coverage for hospice care as an option for individuals and groups.

The term "hospice care facility" is changed to "hospice care program," and "hospice care program" is redefined to mean a coordinated, interdisciplinary program for meeting the special needs of dying patients and their families by providing palliative and supportive medical, nursing and other services through home or inpatient care.

The definition of hospice is changed to describe a facility that provides a hospice care program which is separate from any other facility and admits at least two but not more than eight unrelated, six-month terminal patients.

"Hospice care service" is defined as any service that a hospital, related institution, home health agency, hospice, or other licensed facility provides under a hospice care program.

MICHIGAN

HB 4909, Public Act 293 (1980)—Michigan's first hospice law states that, for the purpose of regulation, hospice is included in the definition of a health facility or agency. The title of hospice may not be used unless the organization is licensed by the department as a hospice.

A hospice which provides the services of a home or any other health facility or agency must obtain a separate license for that operation. Inspections and licensure will be conducted concurrently if separate licenses are required.

Owners, operators and governing bodies are responsible for quality of care and services, and must cooperate with the department and require personnel be licensed if mandated. The hospice, in accordance with NHO definition, must be under the direction of a physician.

No patient may be admitted without a six-month terminal prognosis, but life beyond this period will not make a patient ineligible for continued hospice care.

All hospices are exempt from license fees for three years from the time that the first hospice is licensed under this article.

The department is given one year to issue rules. This law will expire after seven years.

NEW YORK

S 9755, Chapter 797 (1982)—This act creates a demonstration program to evaluate the use of hospices within the health care system and to develop a cost benefit reimbursement methodology for hospice care. The demonstration will consist of three hospice models, one each to evaluate the hospice program of home care with back-up inpatient beds provided: 1) in a special, autonomous unit of a general hospital or of a nursing home; 2) in a freestanding hospital facility; and 3) in whatever unit of a general hospital to which the patient may be admitted.

VIRGINIA

HJR 80 (1980)—The legislature requested the appointment of a joint subcommittee to work with the Hospice Advisory Committee, established in 1979, to make recommendations regarding quality standards, licensure and reimbursement of hospice programs. Issues of licensure and standards were to be resolved prior to the development of an appropriate reimbursement system. The committees were to present legislative proposals in 1981.

SJR 145 (1981)—The Department of Health and the Hospice Advisory Committee are requested to continue evaluations of Virginia hospices, with a findings report due in 1983.

SB 700 (1981)—"Hospice" is defined as a coordinated program of home and inpatient care, providing palliative and supportive medical and other health services through a medically directed interdisciplinary team, available at all times.

This act does not apply to hospices operated by a recognized church or denomination which provides care by spiritual means without the use of drugs or material remedy. Such a hospice must comply with environmental protection and life safety.

Provisions of the act include:

- the requirement of a license for hospice operation;
- establishment of an annual licensing procedure and periodic inspections by the Commissioner;
- the prescription of hospice regulation by the Board;
- incorporation of regulations applicable to hospitals, nursing homes or home health agencies which are also applicable to hospices, to avoid duplication.

Failure to comply with the article provisions or with Board regulations may result in revocation or suspension of the hospice license.

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